Supreme Court, U.S.
FILED
NOV 19 1987
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CLERK

No. 86-1764

In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION AND
THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTIONS PRESENTED FOR REVIEW

1. Where a Medicare regulation prohibits certain reimbursement and the fiscal intermediary has no authority to deviate from the regulation, can the Provider Reimbursement Review Board refuse to exercise jurisdiction over a provider's appeal to challenge the regulation on the ground that the provider complied with the regulation when completing the Medicare cost report it filed with the intermediary?

2. Even if the Secretary has authority to require a provider to dispute a regulation when filing its cost report, can the Secretary implement such a requirement without notice to the provider?

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings below were the petitioners Bethesda Hospital Association and The Deaconess Hospital of Cincinnati, Ohio, and the Respondent Otis R. Bowen, M.D., Secretary of Health and Human Services.

The following Ohio hospitals were also plaintiffs-appellees in the proceedings below: Bethesda Hospitals, Inc. of Cincinnati; Brown County General Hospital; Clinton Memorial Hospital; Doctors Hospital, Inc.; Doctors Hospital of Nelsonville; Good Samaritan Medical Center; Grady Memorial Hospital; Guernsey Memorial Hospital; Kettering Medical Center; Lancaster-Fairfield Community Hospital; Madison County Hospital, Inc.; East Ohio Regional Hospital, Inc. d/b/a Martins Ferry Hospital; Medical Center Hospital; Memorial Hospital of Union County; The Mercy Hospital Corporation; Mercy Memorial Hospital of Urbana, Ohio, Inc.; Miami Valley Hospital; Ohio State University Hospitals; Our Lady of Mercy Hospital of Mariemont; Pike Health Services, Inc., d/b/a Pike Community Hospital; Riverside United Methodist Hospital; St. Ann's Hospital of Columbus, Inc.; St. John Medical Center; Sycamore Medical Center; and Shelby County Memorial Hospital Association, d/b/a Wilson Memorial Hospital. Because these hospitals are not affected by the jurisdictional issue presented for review, they are not named as parties herein.

The parent company of petitioner Bethesda Hospital Association is Care One Health Systems, Zanesville, Ohio.

The parent company of petitioner The Deaconess Hospital of Cincinnati, Ohio is The Deaconess Associates, Inc., Cincinnati, Ohio.

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BRIEF FOR THE PETITIONERS

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-8a) is reported at 810 F.2d 558. The opinion of the district court (Pet. App. 29a-51a) is reported at 609 F. Supp. 1360. The decision of the Provider Reimbursement Review Board (Pet. App. 52a-58a) is not reported.

JURISDICTION

The judgment of the court of appeals was issued and entered on February 2, 1987. The judgment was amended by an order entered February 25, 1987. Pet. App. 9a. The petition for rehearing en banc was filed February 17, 1987, and was denied by order dated July 1, 1987. Jt. App. 68a.

The petition for a writ of certiorari was filed on May 2, 1987, and was granted on October 5, 1987. The jurisdiction of this Court rests upon 28 U.S.C. § 1254(1) (1982).

STATUTES INVOLVED

This case involves the statute creating the Provider Reimbursement Review Board, 42 U.S.C. § 1395oo (1982). The statute is reprinted in the appendix.

STATEMENT OF THE CASE

Introduction

This case arises in the context of a hospital industry-wide challenge to the Secretary's regulatory change in the way the Medicare program reimburses hospitals for their costs of malpractice insurance. The courts have resoundingly rejected the merits of this change in reimbursement methodology. As a result, the Secretary has had to pay millions of dollars, including substantial interest payments, to provider hospitals to remedy the Medicare reimbursement they lost under the attempted change.

The Secretary, however, refuses to pay the hospital petitioners, contending that because they complied with the now-discredited regulation in completing their Medicare cost reports, they cannot be permitted to enter the administrative and judicial review process to challenge the regulation. This position denies the hospitals access to the only forum in which they can press their claim that they were underpaid, and takes advantage of a natural inclination to follow instructions in completing complicated filings. Such a position is not supported by the Medicare statute.

Medicare Reimbursement Scheme

During the 1980 cost year here at issue,[1] hosp'tals certified to participate in the Medicare program established

[1] For cost years beginning on or after October 1, 1983, most hospitals became subject to the Medicare prospective payment system (PPS). Under PPS, hospitals are paid a predetermined amount for each discharge, which varies according to the diagnosis of the patient. 42 U.S.C. § 1395ww(d) (1982). Certain costs for PPS hospitals (outpatient, capital, medical education), as well as hospitals exempt from PPS (children's hospitals, psychiatric and rehabilitation hospitals), skilled nursing facilities and home health agencies, are still subject to reasonable cost reimbursement.

by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ww (1982), generally were reimbursed the "reasonable cost" of providing services to Medicare patients. 42 U.S.C. §§ 1395f(b) (1982), 1395x(v)(1)(A) (1982)[2]. The petitioners, Bethesda Hospital and Deaconess Hospital (hereinafter "Hospitals") are providers of inpatient hospital services to Medicare beneficiaries, pursuant to a provider agreement with the Secretary of Health and Human Services ("Secretary"). This case arises from the attempt of the Hospitals first to challenge the Secretary's 1979 regulation, 42 C.F.R. § 405.452(b)(1)(ii)(1979) ("the 1979 Malpractice Rule"), and then to challenge the retroactive application of 42 C.F.R. § 413.56 (1986) ("the 1986 Malpractice Rule") which the Secretary adopted after the 1979 Malpractice Rule and had been invalidated.

The 1979 Malpractice Rule radically altered the utilization method used by the Medicare program since its inception in 1966 to apportion malpractice insurance costs between Medicare and non-Medicare patients for reimbursement purposes.[3] The two Hospitals were first subject

[2] Section 1395f(b) . quires the Secretary to pay a hospital the lesser of the "reasonable cost" of its services or its customary charge. Only in unusual circumstances are a hospital's customary charges less than its reasonable cost.

[3] Under the utilization method, malpractice premium costs were aggregated with other indirect costs, such as business office costs. After interim allocations, all these indirect costs were allocated to revenue producing cost centers in the hospital, based upon the ratio of accumulated costs of such cost centers. Once allocated, the malpractice and other indirect costs would be apportioned between Medicare and

to the 1979 Malpractice Rule for their fiscal year beginning January 1, 1980 and ending December 31, 1980.

After the close of the year, the Hospitals submitted to their fiscal intermediary[4] a Medicare cost report, in the form mandated by the Secretary. The cost report includes every cost incurred by a hospital for each and every activity in which it engages—whether or not the activity represents a reimbursable activity or, for that matter, a patient care activity. These costs are entered upon various schedules and worksheets in the cost report which serve to allocate costs to the various reimbursable and non-reimbursable cost centers and then, for the reimbursable cost centers, to apportion the costs between Medicare and non-Medicare patients. By completing the component schedules of the cost report according to the Secretary's instructions and regulations, the hospital calculates its Medicare reimbursement. The submission of a cost report is not an adversary proceeding but merely triggers an accounting audit.

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non-Medicare patients for each such cost center based upon usage, i.e. if a hospital had an intensive care unit as a cost center and 41% of the patient days were Medicare patient days, Medicare would reimburse the hospital 41% of the malpractice premium and other indirect costs that had been allocated to the intensive care unit.

Under the 1979 Malpractice Rule, malpractice premium costs were removed from the pool of indirect costs and apportioned based upon actual claims history. Thus, a hospital with a $100,000 malpractice insurance premium might receive payment ranging from nothing to 100% of its cost, depending upon whether it had any malpractice loss experience and, if so, whether there were any Medicare patients involved.

[4] A fiscal intermediary is a private organization, usually an insurance company, that contracts with the Secretary to perform Medicare payment and audit activities and other selected functions on the Secretary's behalf. 42 U.S.C. § 1395h (1982). Heckler v. Community Health Services of Crawford County, 467 U.S. 51, 54 (1984).

The intermediary audits the cost report in accordance with the Secretary's regulations and policies. If the intermediary disallows, reallocates, or reapportions all or part of any category of costs, it prepares an audit adjustment report listing such disallowances and related adjustments. The intermediary then issues its determination of the reimbursement due the hospital for services rendered to Medicare beneficiaries, called a Notice of Program Reimbursement ("NPR"). The NPR and the audit adjustment report that accompanies the NPR explain any revisions made to the calculations in the cost report by the intermediary during the audit to bring it into conformity with regulations, and reconciles any interim payments the hospital may have received during the year with the total amount payable. 42 C.F.R. § 405.1803 (1986).

When the Hospitals filed their cost reports for FY 1980, they complied with the 1979 Malpractice Rule by completing Worksheet D-8 to the Medicare cost report, "Apportionment of Malpractice Insurance Costs." Jt. App. 58a-61a. Worksheet D-8 required hospitals to list their total malpractice insurance costs on line 11, and then to apply the methodology of the 1979 malpractice regulation in apportioning those costs to the Medicare program. The Hospitals' cost reports thus did include a claim for reimbursement for malpractice insurance costs, but completion of Worksheet D-8 effectuated a "self-disallowance" of those malpractice insurance costs in excess of those allowed under the apportionment methodology of the 1979 Rule. Because these Hospitals complied with the Secretary's regulation and cost report instructions, there was no need for the fiscal intermediary reviewing their cost reports to make an audit adjustment with respect to malpractice insurance costs before it issued an NPR.

Medicare Appeals Scheme

The Medicare statute provides for administrative and judicial review of the NPR. 42 U.S.C. §§ 1395oo(a), (f) (1982). The first stage of the review process is an appeal to the Provider Reimbursement Review Board (hereinafter "PRRB" or "Board"). A hospital must meet the jurisdiction requirements of 42 U.S.C. § 1395oo(a) in order to obtain administrative review by the PRRB of the amount of reimbursement contained in the NPR. Section 1395oo(a) provides:

> Any provider of services which has *filed a required cost report within the time specified in regulations* may obtain a *hearing with respect to such cost report* by a Provider Reimbursement Review Board . . ., *if* (1) such provider – –
>
> (A)(i) *is dissatisfied with a final determination* of the organization serving as its fiscal intermediary pursuant to section 1395h of this title *as to the amount of total program reimbursement* due the provider for the items and services furnished to individuals for which payment may be made under this sub-chapter for the period covered by such report, . . .
>
> • • •
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i). . . .

(emphasis added).

Once the jurisdictional requirements of subsection (a) are met and the Board has jurisdiction to hear an appeal, the powers and scope of review of the PRRB are discussed in section 1395oo(d) (1982):

> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report *and to make any other revisions on matters covered by such cost report* (including revisions adverse to the provider of services) *even though such matters were not considered by the intermediary in making such final determination.*

(emphasis added).

Judicial review of decisions by the Board is specifically provided in 42 U.S.C. § 1395oo(f).

Course of Proceedings Below

Upon receiving their NPRs, the two Hospitals joined with a group of Ohio hospitals and filed requests for a hearing before the PRRB, seeking reimbursement for malpractice insurance costs under the pre-1979 utilization methodology and challenging the 1979 Malpractice Rule. With respect to all the other providers in the group appeal, the Board found it had jurisdiction over the appeal, and permitted those providers to file their challenge to the 1979 Malpractice Rule directly in federal district court under the expedited judicial review provisions of section 1395oo(f)(1) (1982).[5]

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[5] The Board is bound by the Secretary's regulations. 42 C.F.R. § 405.1867 (1986). As discussed at pages 22 and 30, below, the third through sixth sentences of section 1395oo(f)(1) provide that where a provider seeks to challenge the validity of a regulation by which the Board is bound, the Board can issue a determination that it cannot decide the issue in the case. The provider thereupon can proceed directly to federal district court to challenge the regulation.

However, the Board denied jurisdiction over the Hospitals' appeal, contending that in order to appeal to the Board the Hospitals had to complete Worksheet D-8 incorrectly so as to apportion malpractice premium costs to Medicare in excess of the amounts allowed by the 1979 Malpractice Rule, or otherwise state its claim. Thereupon, the intermediary could make an audit adjustment to reapportion the Hospitals' malpractice premium costs in accordance with the 1979 Malpractice Rule and thereby disallow the costs above those permitted by the 1979 Malpractice Rule. Pet. App. 54a. The Board decided that this was required to meet the statutory requirement of section 1395oo(a)(1)(A)(i) (1982) that a provider be "dissatisfied with a final determination" of the intermediary. *Id.*

All the providers (including the two Hospitals) appealed to federal district court, pursuant to 42 U.S.C. § 1395oo(f)(1). The district court subsequently invalidated the 1979 Malpractice Rule (Pet. App. 42a-51a), as did the Sixth Circuit in another case, *Cumberland Medical Center v. Secretary of Health and Human Services,* 781 F.2d 536 (6th Cir. 1986).[6] The Secretary appealed the district court decision and, during the pendency of the appeal, adopted

[6] While not a single appellate court has upheld the 1979 Malpractice Rule, numerous courts have invalidated it. *See, e.g.,* Bedford County Memorial Hospital v. Health and Human Services, 769 F.2d 1017 (4th Cir. 1985); Menorah Medical Center v. Heckler, 768 F.2d 292 (8th Cir. 1985); DeSoto General Hospital v. Heckler, 766 F.2d 182 (5th Cir. 1985); Lloyd Noland Hospital and Clinic v. Heckler, 762 F.2d 1561 (11th Cir. 1985); St. James Hospital v. Heckler, 760 F.2d 1460 (7th Cir.), *cert. denied,* 474 U.S. 902 (1985); Humana of Aurora, Inc. v. Heckler, 753 F.2d 1579 (10th Cir.), *cert. denied,* 476 U.S. 863 (1985); Abington Memorial Hospital v. Heckler, 750 F.2d 242 (3d Cir. 1984), *cert. denied,* 474 U.S. 863 (1985); Walter O. Boswell Memorial Hospital v. Heckler, 628 F. Supp. 1121 (D.D.C. 1985).

the revised 1986 Malpractice Rule, with retroactive effect to July 1, 1979. The Sixth Circuit, following its earlier decision in *Mason General Hospital v. Secretary of the Department of Health and Human Services,* 809 F.2d 1220 (6th Cir. 1987), ruled in favor of the 25 other hospitals in the group appeal and invalidated retroactive application of the 1986 Malpractice Rule.[7] Pet. App. 4a.

With respect to the two Hospitals, the district court reversed the decision of the Board denying jurisdiction over their appeals. The court found that the plain language of section 1395oo(d), which authorizes the Board "to make any other revisions on matters covered by [the] cost report . . . even though such matters were not considered by the intermediary in making such final determination," gives the Board jurisdiction to hear self-disallowed claims, despite the fact the intermediary did not first deny such claims. Pet. App. 34a-35a. The district court also held that the doctrine of exhaustion of administrative remedies does not support the Secretary's position that claims must first be presented to the intermediary, because the intermediary is bound by the Secretary's regulations and therefore cannot grant the relief the petitioners seek, i.e., invalidation of the 1979 Malpractice Rule. Pet. App. 40a-41a.

[7] To date three courts of appeals have invalidated the 1986 Malpractice Rule insofar as it is retroactively applied to prior years. Mason General Hospital v. Secretary of the Department of Health and Human Services, 809 F.2d 1220 (6th Cir. 1987); Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d 1435 (11th Cir. 1987), *cert. pending,* No. 87-830; St. Peter's Medical Center v. Bowen, No. 86-5371 (3d Cir., February 23, 1987). The Seventh Circuit, while not ruling on the merits or retroactivity of the 1986 Rule, remanded the case to the Secretary for application of the 1986 Rule. Appleton Memorial Hospital v. Bowen, 814 F.2d 408 (7th Cir. 1987).

The Sixth Circuit reversed the decision of the district court on the self-disallowance issue because it was bound by the previous decision of another panel of the Sixth Circuit in *Baptist Hospital East v. Secretary of Health and Human Services,* 802 F.2d 860 (6th Cir. 1986). Pet. App. 10a-28a. The panel in *Baptist Hospital East* found that where a provider complies with the Secretary's regulation in completing its cost report and effects a self-disallowance, it has disclaimed entitlement to reimbursement for costs in excess of those allowed under the regulations. Pet. App. 14a. The *Baptist Hospital East* panel adopted the analysis of the Court of Appeals for the D.C. Circuit in *Athens Community Hospital, Inc. v. Schweiker,* 743 F.2d 1 (D.C. Cir. 1984) (*Athens II*), *modifying* 686 F.2d 989 (1982) (*Athens I*). *Athens II* held that in order for the Board to have jurisdiction over a provider's appeal, a provider must present a claim for reimbursement by completing the cost report in a manner that will force an intermediary disallowance or otherwise notify the intermediary of its dispute before the intermediary issues the NPR.[8]

The result of the Sixth Circuit decision is that the Hospitals are thus reimbursed for their malpractice insurance costs according to the methodology of the 1986

[8] The earliest appellate decision on the self-disallowance issue was that of the Seventh Circuit in St. Mary of Nazareth Hospital Center v. Department of Health and Human Services, 698 F.2d 1337 (7th Cir.), *cert. denied,* 464 U.S. 830 (1983), which held that the PRRB has jurisdiction over self-disallowance. The Fourth Circuit and the Eleventh Circuit followed the *Athens* decision, and held against the hospitals. Community Hospital of Roanoke Valley v. Health and Human Services, 770 F.2d 1257 (4th Cir. 1985); North Broward Hospital District v. Bowen, 808 F.2d 1405 (11th Cir. 1987), *cert. pending,* No. 86-1986.

Most recently, the Ninth and Eleventh Circuits have rejected the *Athens* rationale and concluded that the Board must hear appeals of

Malpractice Rule,[9] despite the fact the Sixth Circuit has held that the 1986 Rule cannot be retroactively applied to these cost years.

SUMMARY OF ARGUMENT

The Secretary's policy of denying administrative and judicial review to providers that self-disallow costs by following the Secretary's regulations is inconsistent with the plain language and intent of section 1395oo and therefore is invalid. The statute sets forth only four requirements to permit a provider to appeal to the Board. A provider must (1) file a cost report; (2) be dissatisfied with

self-disallowances. Adams House Health Care v. Heckler, 817 F.2d 587 (9th Cir. 1987), *cert. pending,* No. 87-443; Tallahassee Memorial Regional Medical Center, 815 F.2d 1435 (11th Cir. 1987), *cert. pending,* No. 87-380 (distinguishing *North Broward* on the grounds that *Tallahassee* involved a challenge to a regulation while *North Broward* did not, thereby invoking a different authority for judicial review). The First Circuit has also rejected *Athens,* but concluded that the Board has discretionary authority to hear appeals of self-disallowances. St. Luke's Hospital v. Secretary of Health and Human Services, 810 F.2d 325 (1st Cir. 1987).

[9] Following publication of the 1986 Malpractice Rule, the Hospitals received a supplemental payment which increased their reimbursement over what they would have received under the 1979 Malpractice Rule, but which still reimbursed them substantially less than they would have received under the utilization methodology. The Secretary has indicated that the 1986 Malpractice Rule will not be retroactively applied to hospitals that self-disallowed under the 1979 Malpractice Rule. *Tallahassee,* 815 F.2d at 1449 n.26. Thus there is a possibility that the Secretary will seek to recoup the payments made to the Hospitals under the 1986 Malpractice Rule, leaving the Hospitals reimbursed under the totally repudiated methodology of the 1979 Malpractice Rule.

its total amount of reimbursement; (3) have the requisite amount in controversy; and (4) timely file an appeal. The Secretary contends that the Hospitals did not have the requisite dissatisfaction because they did not dispute the 1979 Malpractice Rule with the intermediary when they filed their cost reports so that the intermediary could disallow those costs not allowed by the regulation. There is nothing in the language of the statute to support the Secretary's interpretation that a provider can appeal only what the intermediary has expressly disallowed.

Alternatively, even if the Court finds the Secretary's interpretation to be a plausible reading of the statute, there are no practical considerations to support that interpretation and thus it is not entitled to deference. To require a provider to violate a regulation or manual provision when completing its cost report merely so that the intermediary can make an audit adjustment, when the intermediary is bound by the regulations and manual provisions and can provide no relief, is a wasteful exercise that accomplishes nothing. So long as costs are included in the cost reporting process, the Secretary's interests in the orderly administration of the Medicare program are not jeopardized by a reading of the statute that permits providers to appeal their challenges to regulations and manual provisions to the PRRB, whether or not a provider complied with those provisions in completing the cost report. Because malpractice insurance costs are a category of costs included in the normal cost reporting process, there is no danger that the provider can raise stale or frivolous claims.

In addition, a reading of the statute which vests in the Secretary the authority to restrict access to administrative and judicial review, when the statute does not expressly exclude self-disallowing providers from such access, runs afoul of the presumption favoring judicial review and permits a delegation which unduly restricts the waiver of sovereign immunity granted by Congress. Finally, in any

event, the Hospitals cannot be deprived of review when they were given no notice that, by complying with the then-new 1979 Malpractice Rule, they were abandoning their right to challenge that regulation.

The Circuits have split on the question whether the PRRB has jurisdiction over appeals concerning self-disallowed costs. The split arises from the decisions of the D.C. Circuit in *Athens I* and *II*. The *Athens* decisions are wrong because the court confused the section of the statute which delineates the powers of the PRRB once it has jurisdiction over an appeal with the section which delineates the jurisdictional requirements a provider must meet to appeal to the PRRB. The court also misconstrued the practical consequences of the Secretary's interpretation.

ARGUMENT

I. THE SECRETARY'S POLICY OF DENYING ADMINISTRATIVE AND THEREBY JUDICIAL REVIEW IS INCONSISTENT WITH THE PLAIN LANGUAGE OF THE STATUTE.

The starting point for any analysis of a statute is the language of the statute itself. *Consumer Product Safety Commission v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980). Two subsections of section 1395oo are relevant here. Subsection (a) sets forth the jurisdictional criteria a provider must meet to be entitled to a hearing at the Board, while subsection (d) sets forth the functions of the Board upon hearing the provider's claim. The Secretary's interpretation that an intermediary audit adjustment is required in order for a provider to appeal to the Board is not supported by the statutory language in either of these provisions.

A. The Hospitals Meet The Statutory Requirement In Section 1395oo(a) That They Be Dissatisfied With The Total Amount Of Reimbursement.

At the outset, it is important to realize that subsection (a), not subsection (d), sets forth the jurisdiction of the

Board in terms of those providers that may appeal to the Board. The reason that the self-disallowance issue has become so confused is that the analysis in *Athens* and in virtually all the other decisions has been based on the fundamental error that subsection (d) rather than (a) is the jurisdictional basis for administrative relief for the aggrieved provider. This is most clearly stated in *Athens II*, where the court states: "The PRRB's jurisdiction – –the crux of the dispute here – –is set out in section 1395oo(d) . . . ." 743 F.2d at 3. Section 1395oo(a) is characterized by the *Athens* court as setting forth the PRRB's functions. *Id.* at 6.

A reading of the statutory subsections makes it readily apparent that the *Athens* court has reversed the thrust of the statutory subsections through its characterization. Section 1395oo(a) clearly establishes the PRRB's jurisdiction when it sets forth: (1) those events upon which the provider may take a claim to the PRRB (i.e., the filing of a cost report and dissatisfaction with the total amount of reimbursement offered by the intermediary); (2) the jurisdictional amount ($10,000); and (3) the time within which the appeal must be filed. Section 1395oo(d), on the other hand, governs the Board's conduct once it has jurisdiction over a provider's appeal, requiring the Board's decision to be based upon the record made at the hearing and supported by substantial evidence. It also authorizes the Board to act with regard to other aspects of the cost report before it, even though those aspects may not have been disputed with or taken into account by the intermediary in making its final determination.

Recognizing, then, that subsection (a) governs the Board's jurisdiction, an analysis of that subsection reveals the Board has jurisdiction under that provision to hear self-disallowed costs if the provider meets four conditions. The only issue in dispute here is whether the Hospitals have met the requirement of being dissatisfied with their total amount of reimbursement.

Subsection (a)(1)(A)(i) provides that a hospital may obtain a hearing if it is "dissatisfied with a final determination of [the intermediary] as to the amount of total reimbursement due the provider." There is no dispute between the parties that the "final determination of the amount of program reimbursement" is the NPR received by the Hospitals from the intermediary. *See* 42 C.F.R. § 405.1801 (1986).

All that the plain language of this subsection requires is that the provider be dissatisfied with the *total* amount of reimbursement offered in the NPR, as determined by the Secretary's regulations. Nothing requires that the dissatisfaction be with respect to a particular intermediary audit adjustment. *Adams House Health Care v. Heckler*, 817 F.2d 587, 592 (9th Cir. 1987), *cert. pending*, No. 87-443 ("Section (a) requires that a provider be dissatisfied with the total amount of reimbursement offered by an intermediary, not with the intermediary's reasoning process with respect to any specific costs.").

Furthermore, it is significant that Congress used the words "*is* dissatisfied with a *final* [intermediary] determination" (emphasis added), rather than words like "has expressed dissatisfaction to the Intermediary before the final determination is issued." The wording thus requires that the provider be dissatisfied at the time it receives its NPR, not beforehand. Moreover, the wording states that the provider must only *be* dissatisfied, not that the provider must have *expressed* that dissatisfaction to the intermediary. The provider subsequently expresses that dissatisfaction by appealing to the PRRB.

With regard to the statutory requirement of "dissatisfaction," *Athens II* concluded:

> We do not think Congress intended to permit a provider to claim dissatisfaction based upon its own failure to request reimbursement of a cost item. If a provider is unhappy with the reimbursement the in-

> termediary allowed in such a case, it is the fault of the provider and not the intermediary. It is simply not plausible to contend that Congress has created a scheme where the provider can claim dissatisfaction and have recourse to an appeal procedure because the intermediary failed to read the provider's mind and anticipate all those things the provider would like to be reimbursed for, even though it did not request them.

743 F.2d at 6 (footnote omitted). Here the *Athens* court drew an implausible inference as to Congressional intent that is adverse to the provider's right to be heard without any basis in the language of the statute or its legislative history. Simply put, Congress stated that a provider can appeal when dissatisfied with the determination of the amount of total reimbursement. It is not plausible that Congress intended that the provider should be required to refuse to follow regulations and instructions in completing a cost report, to the great inconvenience of the intermediary, in order to have a right to be heard to challenge a manual instruction or regulation which the intermediary is bound to follow in any event. A provider can hardly be said to be at fault or neglectful when it was following the Secretary's regulations and, as discussed below, when it would have been pointless to dispute the regulation with the intermediary. *Adams House*, 817 F.2d at 592.

The jurisdictional determinant under subsection (a) is the *provider's* dissatisfaction with the total reimbursement due following submission of the cost report, not the *Board's* ability to make revisions to such matters. The Hospitals in this case were dissatisfied with the total reimbursement offered by the intermediary in their NPRs because it was calculated using the 1979 Malpractice Rule. Their dissatisfaction stems from an unlawful regulation which the intermediary was required to follow. The statute requires nothing more in the way of dissatisfaction.

B. The Statute Does Not Limit The Board Hearing To Items Which The Intermediary Has Adjusted.

The plain language of other portions of section 1395oo indicates that the scope of the hearing before the PRRB is broad, and is not limited solely to items for which the intermediary has written an audit adjustment.

1. Subsection (a) Provides That The Hearing Is About The Cost Report.

Subsection (a) provides that if a provider has filed a cost report and has met the other specified criteria, it "may obtain a hearing *with respect to such cost report*" (emphasis added). The statute does not say that the hearing is limited to intermediary adjustments to the cost report, but rather concerns the cost report as a whole.

This raises the issue of what constitutes a cost report. The "report" is not a single page or schedule, but rather a voluminous document with schedules, worksheets, and supplemental worksheets. (*See* checklists, first page of cost report excerpts, Jt. App. 35a-36a; 45a-46a). The Provider Reimbursement Manual (HIM-15) specifies which schedules and worksheets must be filed by each type of provider with its fiscal intermediary. The ultimate array of schedules and worksheets is determined by such questions as whether the provider is a hospital or nursing home, whether it is for-profit or non-profit, and which services it furnishes.

Acute general hospitals, such as the two Hospitals in question, are required to file with their intermediary, as part of the cost report, various schedules and worksheets. These include Worksheet A, "Reclassification and Adjustment of Trial Balance of Expenses," (Jt. App. 39a, 50a), Worksheet A-8, "Adjustments to Expenses," (Jt. App. 41a, 52a), and Worksheet D-8, "Apportionment of Malpractice Insurance Costs," (Jt. App. 58a-61a), each of which includes malpractice insurance premium costs.

Thus, the phrase "with respect to such cost report" in subsection (a) certainly includes costs of malpractice in-

surance, which must be entered on at least three worksheets of the cost report. Whether or not the intermediary adjusted those particular cost items in the process of making a final determination, the Hospitals are entitled to a hearing "with respect to such cost report", including the fact that the 1979 Malpractice Rule was required to be applied to their claim for reimbursement of malpractice insurance costs by means of Worksheet D-8.

When the *Athens I* panel described subsection (a) as "limit[ing] PRRB review to matters *raised by* the original cost report," 686 F.2d at 995 (emphasis added), the court then clearly erred. The operative statutory language in section 1395oo(a) is that a provider may obtain "a hearing *with respect to such cost report*." To substitute the words "raised by" for "with respect to" is unwarranted and is not supportable.

2. ***The Malpractice Insurance Costs Here At Issue Were Matters "Covered By Such Cost Report" Within The Meaning Of Subsection (d).***

Once a provider is entitled to a hearing, subsection (d) delineates a broad function for the PRRB:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report *and to make any other revisions on matters covered by such cost report* (including revisions adverse to the provider of services) *even though such matters were not considered by the intermediary* in making such final determination.

42 U.S.C. § 1395oo(d) (emphasis added).

Congress used an all-inclusive phrase, "matters covered by such cost reports", rather than a more limited phrase such as "intermediary adjustments." As the above discussion of "cost reports" indicates, the Hospitals included reference to their costs of malpractice insurance on at least three worksheets. There is no reasonable interpretation to

be made that the Hospitals' malpractice insurance costs are not "matters covered by [the] cost report."

This conclusion that the Board can review matters for which the intermediary did not write an adjustment is bolstered by the language in the rest of the sentence: the Board can make revisions on matters "even though such matters were not considered by the intermediary in making a final determination." Obviously, if an intermediary has written an audit adjustment on an issue, it has "considered" the matter. This phrase must therefore mean that the Board has the power to make revisions on matters where the intermediary has *not* written an audit adjustment, *e.g.*, self-disallowed costs. *St. Luke's Hospital v. Secretary of Health and Human Services*, 810 F.2d 325, 328 (1st Cir. 1987).

Because the interpretative focus by the Circuits has been on the *Athens* reading of section 1395oo(d), it is useful to analyze the *Athens* decisions as if they correctly characterized subsection (d) as the statutory grant of jurisdiction. The *Athens I* panel first concluded that subsection (d) is "clearly limited to revisions of matters covered by the original cost report and does not authorize the Board to consider new claims." *Athens I*, 686 F.2d at 995. This reading does not preclude review of self-disallowed costs, because they do appear in the cost report. *Adams House*, 817 F.2d at 591 ("a cost is 'covered by a cost report' if it was incurred within the period which is the subject of the report and is reflected in that report, even if it is not expressly claimed.")

In *Athens II*, the court again proceeded as if subsection (d) constituted the jurisdictional grant to the PRRB, and again its analysis is flawed. *Athens II* begins by specifically rejecting the Seventh Circuit's reading of the statute in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983), on the basis that its reading of the statute ignores and would make meaningless that part of subsection (d) "limiting the PRRB's power 'to af-

firm, modify, or reverse a prior decision of a fiscal intermediary . . . and to make . . . revisions to *matters covered by [that] cost report.* ' " 743 F.2d at 6.[10] The *Athens II* court thereupon purports to read section 1395oo(d) "in light of the Board's functions set out by section 1395oo(a)." *Id.* However, as discussed above, the *Athens II* court misconstrued the language of subsection (a) with respect to the requirement that a provider be "dissatisfied".

An overriding flaw is that the *Athens II* court reaches an internally inconsistent position with respect to its interpretation of subsection (d). At the beginning of its decision, the court describes subsection (d) as "embodying two *separate* jurisdictional grants[:]" first, to affirm, modify or reverse an intermediary determination, and second, to make revisions on matters covered by the cost report not considered by the intermediary. *Id.* at 4 (emphasis added). The court expressly found that "[j]urisdiction exists if the terms of *either* of these two clauses are satisfied." *Id.* (emphasis added).

At the end of its tortured analysis of subsection (d), however, the *Athens II* court ignores its earlier and obvious reading of the language, and concludes that second grant of jurisdiction can be used *only if* the Board has exercised the first grant; that is, the Board can make revisions to matters

[10] The Court had previously erroneously described *St. Mary of Nazareth* as being the most expansive reading of § 1395oo(d), which would include jurisdiction for matters not disclosed to the intermediary through the cost reporting process, assuming that there had been no self-disallowance in that case. 743 F.2d at 5. However, in *St. Mary of Nazareth* the provider in fact had listed its patient telephone costs on its cost report and then had self-disallowed those costs in accordance with 42 C.F.R. § 405.310(j) (1983). *St. Mary of Nazareth*, 698 F.2d at 1340-41. Thus the holding of *St. Mary of Nazareth* must be limited to its facts—the Board has jurisdiction to hear self-disallowed costs which are part of the cost reporting process.

covered by the cost report under the second grant *only* as necessary to accomodate revisions made under the first grant. *Id.* at 9. *Athens II* justifies its conclusion on the grounds that its interpretation of subsection (d) is necessary to give meaning to both the Board's powers. *Id.* As the First Circuit noted, however, why would Congress have to write a special clause into the statute to give the Board the power to make revisions "necessary" to accommodate other provisions, when that power is inherent in the power to affirm, reverse or modify a decision before it? *St. Luke's Hospital,* 810 F.2d at 330.

While the First Circuit in *St. Luke's* is correct in its criticism of *Athens*, it, too, erred in its construction of subsection (d). The *St. Luke's* court read the words "shall have the power" as vesting the PRRB with a discretionary power to grant providers the right to be heard with respect to self-disallowed costs. 810 F.2d at 327.

This construction by the *St. Luke's* court is wrong for two reasons. First, as discussed above, it is subsection (a), not subsection (d), that establishes the PRRB's jurisdiction. And second, as the Ninth Circuit noted, the discretionary language "shall have the power" in subsection (d) refers to "the Board's options once an appeal is filed", not to the Board's power to refuse to hear an appeal at the outset. *Adams House,* 817 F.2d at 594. Moreover, to the extent the phrase "may obtain a hearing" in subsection (a) connotes any discretion at all, it is discretion on the part of the *provider* whether to seek a hearing at the Board, not discretion on the part of the Board to deny the hearing. "The Board has no discretion to reject on appeal . . . [for] the word 'may [obtain a hearing' in subsection (a)] connotes not contingency but entitlement." *Id.*

The reading of section 1395oo urged by the Hospitals, and adopted in *Adams House,* provides a more rational interpretation of the words "shall have the power" as that power applies to revisions of matters in the cost report not relied upon by the intermediary. Since the intermediary is merely a government contractor rather than a government

agency, the PRRB is the first time any component of the agency itself reviews the cost report and the intermediary's determination of reimbursement due. The provider should certainly have the right to have a government agency review the determination of the private government contractor, as well as to hear its challenge to agency policy.

C. *Section 1395oo(f)(1) Also Supports PRRB Jurisdiction Over Self-Disallowed Costs.*

The Eleventh Circuit in *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435 (11th Cir. 1987), *cert. pending*, No. 87-830, has provided an alternative analysis of the self-disallowance issue in another case where providers self-disallowed malpractice insurance costs. This analysis of the structure of section 1395oo supports the Hospitals' position that providers that self-disallow costs by following the Secretary's regulations are entitled to judicial review to challenge those regulations.

The court focused on the grant of judicial review found in the third through sixth sentences of section 1395oo(f)(1),[11] which apply to situations where a provider challenges a regulation and seeks to by-pass a hearing at the Board. Prior to the addition of these sentences, this section provided only for judicial review of a decision of the PRRB or, if the PRRB decision was reviewed by the Secretary, of the decision of the Secretary, and required a Board decision following a hearing as provided by subsection (d). Thus a provider that sought to challenge a regulation had to go through a full hearing at the Board, even though the Board had no authority to invalidate the regulation.

The *Tallahassee* court noted that the by-pass provisions added in 1980 permit a provider to obtain judicial review without a hearing at the Board, and refer only to subsection (a) and not to subsection (d). The court thus held that subsection (d), which describes the Board's function at such a hearing, is irrelevant to the analysis of the self-disallowance issue when a regulatory challenge is involved. 815 F.2d at 1461. It therefore logically concluded that *Athens* and its progeny, which focus on the language and meaning of subsection (d), are inapposite. *Id.* at 1462. It further held that so long as a provider meets the requirements of subsection (a), it is entitled to judicial review of its challenge to a Medicare regulation, even if it has self-disallowed costs by following the regulation in completing its cost report. *Id.* at 1463.

As indicated at page 7, above, the Hospitals were part of a group appeal for which expedited judicial review was sought. The PRRB granted expedited judicial review for the other providers but denied jurisdiction over the Hospitals because of their self-disallowances. That is the same posture that the hospitals in *Tallahassee* were in with respect to their self-disallowances. Accordingly, under the *Tallahassee* analysis, the Hospitals would prevail.

II. DEFERENCE TO THE SECRETARY'S INTERPRETATION OF THE STATUTE IS NOT WARRANTED.

The court of appeals in this case ruled against the Hospitals because it was bound by the decision in *Baptist Hospital East*. In that case, one provider followed the Secretary's regulations on bad debts and charity allowances when completing its cost report and then appealed to the PRRB to challenge those regulations. The Sixth Circuit recognized that, had the provider included costs not allowed by the regulations in its cost report, the intermediary had no authority to allow those costs, and that "in this situation, requiring a provider to claim reimbursement does not serve the purpose generally served by exhaustion requirements." Pet. App. 16a. The court thus acknowledged that the self-disallowance policy serves no legitimate purpose. Nonetheless, "even if we see little reason for requiring a provider to raise a claim before a

[11] See Appendix at 3a-4a. These sentences were added by the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 955, 94 Stat. 2599, 2547-48 (1980).

body that cannot address it", the court felt obligated to "defer to the Secretary's interpretation [of the statutory scheme] where it is reasonable." Pet. App. 17a. The Hospitals contend that the Secretary's interpretation of the statute, which limits access to administrative and judicial review, is not reasonable and therefore deserves no deference.

Deference to agency interpretations is applicable only in situations where "the agency is required to apply [legal] standards to a particular set of facts." *I.N.S. v. Cardoza-Fonseca*, ___ U.S. ___, 107 S.Ct. 1207, 1221 (1987). The issue of the Board's jurisdiction is not such a situation. *Adams House*, 817 F.2d at 594. Rather, it involves the interpretation of a contested legal standard, and as such, is "a pure question of statutory construction for the courts to decide." *I.N.S. v. Cardoza-Fonseca*, 107 S.Ct. at 1221. The court, not the agency, is the ultimate arbiter of statutory construction. *Federal Election Commission v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 31-32 (1981); *Volkswagenwerk v. Federal Maritime Commission*, 390 U.S. 261 (1968). In analyzing the language of the statute, the agency's interpretation is not binding, *Bureau of Alcohol, Tobacco and Firearms v. Federal Labor Relations Authority*, 464 U.S. 89, 98 n. 8 (1983).

Moreover, where the agency is not deciding questions of regulatory policy, but rather, major issues of the relationship of the agency to the federal courts, the reasons for deference seem slim indeed. To give much weight to such an agency determination is to allow unwarranted weight to the decision of a party with adverse interests. As to other matters, the agency may theoretically be the disinterested protector of both the regulated group and the public interest. But as to its own freedom from review, the agency is an interested party.

In determining whether any deference is to be accorded to the Secretary's interpretation, the Court must first determine whether Congress has spoken to the issue, as

evidenced by the language of the statute and the legislative history. If it has done so, then the Court's inquiry is at an end. *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). It is only if the Court finds that the statute is susceptible of multiple interpretations that the Court reaches the question whether the agency's interpretation is entitled to deference.

A. *The Statute Is Not Ambiguous.*

It is well established that a prerequisite to applying the principle of deference to agency construction of a statute is that the language of the statute be either silent or ambiguous. *Chevron*, 467 U.S. at 842-43. In this instance, the language of the statute is neither silent nor ambiguous. Rather, as discussed at length above, the plain language of subsection (a) provides that a hospital can obtain a hearing before the PRRB "with respect to [it] cost report," if it is "dissatisfied . . . as to the amount of total program reimbursement due. . . ." The statute does not limit the hearing only to items the intermediary has adjusted on the cost report, but includes *all* items listed in the cost report, even self-disallowed ones.

The language of subsection (d) is even more plain: the Board has the authority to make revisions "on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making the final determination." Congress could not have said any more clearly that the Board can review matters which the intermediary did not consider and for which the intermediary did not write an audit adjustment.

Interpreting the language of section 243(h) of the Immigration and Nationality Act of 1952, Pub. L. No. 82-414, § 243(h), 66 Stat. 163 (1952), this Court stated: "This ordinary and obvious meaning of the phrase is not to be lightly discounted. . . . With regard to this very statutory scheme, we have considered ourselves bound to assume that the legislative purpose is expressed by the ordinary meaning of the words used." *I.N.S. v. Cardoza–Fonseca*, 107 S.Ct. at 1213 (citations omitted).

If the same standard is applied here, there is no need to consider deference further. The ordinary and obvious meaning of the words "dissatisfied . . . as to the amount of *total* reimbursement due . . ." is that the provider is unhappy with the bottom line amount paid for services rendered. That language cannot be limited to mean only those amounts of reimbursement subjected to an audit adjustment. Not only would that limitation put an irrational gloss on the notion of dissatisfaction with the total amount due, but it eliminates whatever harmony there may be between that language and the language of subsection (d), which authorizes PRRB revisions to cost report items that have not been considered or relied upon by the intermediary. Read as the Hospitals urge, under subsection (a), providers have a right to be heard as to any costs in the cost report that are unpaid, whether or not those costs are the subject of an audit adjustment; and under subsection (d), the PRRB has the right to revise any matters in the cost report, whether or not the subject of an audit adjustment. This is a natural reading of the statute, and puts no strain on the construction.

In *I.N.S. v. Cardoza-Fonseca*, quoting *Chevron*, this Court also stated:

> The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent. . . . If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect.

107 S.Ct. at 1221. The congressional intent drawn from the plain language of subsections (a) and (d) is that providers were to have a remedy if dissatisfied with the amount paid for their services. There is not the remotest suggestion that Congress intended the cost reporting process to be a trap for the unwary where the remedy is lost by following the Secretary's regulations and instructions in completing the cost report. Nor does the language suggest

that Congress intended that intermediaries were to be put to the task of recalculating cost reports containing entries contrary to the Secretary's regulations or instructions before a provider could challenge such regulations or instructions. Without Congressional intent to support it, the Secretary's interpretation is not entitled to deference.

B. ***The Legislative History Provides No Indication That An Audit Adjustment Is Required.***

Because the language of the statute is unambiguous, there is no need to even consider the legislative history of section 1395oo. However, a review of the legislative history indicates that the intent of Congress in enacting section 1395oo was to correct the previous absence of an administrative and judicial appeals process, not to put needless obstructions in the path of a provider which seeks to challenge a Medicare regulation. The House Ways and Means Committee acknowledged that "[u]nder present law there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination," and that "it is desirable to prescribe in law a specific appeals procedure for settling disputed final determinations applying to the amount of program reimbursement." H.R. Rep. No. 231, 92d Cong., 1st Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 4989, 5094. *See also* S. Rep. No. 1230, 92d Cong., 2d Sess. 248 (1972).

The only requirements Congress mentioned for appealing the final determination were the timely filing of a cost report, an amount in controversy of $10,000 or more, and the timely filing of an appeal. H.R. Rep. No. 231, *supra* at 5094; S. Rep. No. 1230, *supra* at 249. There is nothing in the legislative history to indicate that a provider must violate a regulation when filing its cost report in order to appeal.

C. ***The Secretary's Interpretation Is Not Reasonable.***

Assuming *arguendo* that the Court finds the intent of Congress, as evidenced by the language of the statute and

the legislative history, to be ambiguous, then the agency's interpretation of the statute can be afforded deference only if it is reasonable. *See I.N.S. v. Cardoza-Fonseca*, 107 S.Ct. at 1225 (Justice Scalia, concurring) and the cases cited therein.[12] The lack of practical considerations to sup-

[12] These decisions reconcile what appears to be a semantic conflict in *Chevron*. The Court states with respect to statutory interpretation that "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute". 467 U.S. at 843. Juxtaposed with this is the statement that where the "legislative delegation to an agency on a particular question is implicit rather than explicit . . . a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Id.* at 844. In each instance the question is one of statutory construction, with the later cases favoring an analysis based on reasonableness as opposed to whether it may be merely a permissible construction, of which there may be more than one. *See, e.g.*, Japan Whaling Ass'n v. American Cetacean Soc., 478 U.S. ____, 106 S. Ct. 2860, 2867-68 (1986); United States v. Fulton, 475 U.S. ____, 106 S.Ct. 1422, 1428 (1986). Moreover, it can hardly be argued that *Chevron* stands for the proposition that an administrative construction of statutory language that may be a permissible construction when reading the language in isolation, but unreasonable when read in the context of the legislative history, regulatory scheme and rights involved, should be given deference.

The reasonableness analysis is well described in a thoughtful article by Judge Breyer, where he says:

> A simpler course of judicial action, (and one that avoids the procedural thicket just mentioned) would be based upon a less literal reading of *Chevron*. The congressional "instruction" hypothetically implied from silence (and possibly other features of the situation) might be read, not as (1) "We delegate to the agency the power to create the law," but rather as (2) "Court, Pay particular attention to a reasonable agency interpretation of the law." This second instruction implies that, if the agency has not offered a reasonable interpretation of the statute in this case; if it has not considered the matter thoroughly; if, in *Skidmore*'s words, the agency's brief lacks "the power to persuade"; then the court should simply decide the question on its own. This second view makes practical sense from the perspective of judicial administration. [Citations omitted in original.]

Breyer, *Judicial Review of Questions of Law and Policy*, 38 Admin. L. Rev. 363, 379 (1986).

port the Secretary's interpretation, and the agency's inconsistent and hostile position on the issue, belie any assertion that the Secretary's interpretation is reasonable.

1. The Secretary's Policy of Denying Administrative And Judicial Remedies To Self-Disallowing Providers Lacks The Practical Underpinnings That Are Necessary To Support A Conclusion That It Is Reasonable.

The *Athens* court points to numerous practical considerations which, it believes, provide a rational basis for the Secretary's restrictive reading of the statute. A closer look at these considerations reveals that, in fact, there are no practical reasons whatsoever to require a provider to disobey a regulation, thereby causing the intermediary to make an adjustment to bring the cost report back into compliance with the regulation, in order for the provider to preserve its appeal rights.

a. The Secretary's Interpretation Imposes An Exhaustion of Remedies Requirement That Makes No Sense.

The *Athens I* court focused on what can be called exhaution of remedies considerations, concluding that to give the PRRB jurisdiction to hear new claims with respect to cost reports before it would have adverse effects. The court believed such jurisdiction would (1) significantly reduce the role of the intermediary, (2) deprive the PRRB of the intermediary's analysis and conclusions, and (3) make the PRRB the tribunal of original jurisdiction, thereby eliminating a tier of review and possibly slowing the reimbursement process for others. 686 F.2d at 997. None of these concerns have any merit with respect to costs that are self-disallowed in compliance with regulations.

(1) *Role of the intermediary.* In the instant case, disputing the validity of the Malpractice Rule with the intermediary would not reduce the intermediary's role, and would have achieved nothing, because the intermediary is bound by the Secretary's regulations and guidelines and could not have granted any relief. Consequently, any

arguments the Secretary may have that claims must be presented to the intermediary, in order that the intermediary should have an opportunity to resolve the issue, are not supported by exhaustion of remedies principles.

The remedy in the administrative scheme is the hearing at the PRRB and not the initial filing of the cost report with the intermediary, which is merely the provider's submission of its request for payment for services rendered filed in accordance with the regulations. Even the Sixth Circuit in *Baptist Hospital East*, which followed *Athens*, recognized that the intermediary was bound to apply the Secretary's regulations and that "in this situation, requiring a provider to claim reimbursement does not serve the purpose generally served by exhaustion requirements." 802 F.2d at 864-65. *Accord, Adams House*, 817 F.2d at 592.

Congress has already indicated that, in challenges to Medicare regulations, such futile procedures are to be avoided. As discussed above at page 22, in 1980 Congress amended section 1395oo(f)(1) to provide that, in situations where the Board was bound by the challenged regulation, the provider could ask the Board for a determination that the Board was "without authority to decide the question." Such a determination by the Board allowed the provider to bypass a hearing at the Board and proceed directly into district court on its challenge to the regulation.

The legislative history indicates that Congress created this by-pass provision to end pointless procedures. After describing the existing requirement that a provider must have a hearing at the Board even where the provider challenges a regulation by which the Board is bound, Congress states:

> The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue time-consuming and irrelevant administrative review merely to have a right to bring suit in a U.S. District Court.

H.R. Rep. No. 1167, 96th Cong., 2d Sess. 394, *reprinted in* 1980 U.S. Code Cong. & Admin. News 5526, 5757. *See also* remarks of Congressman Hettel, 126 Cong. Rec. 22218 (1980), *reprinted in Tallahassee Memorial Regional Medical Center*, 815 F.2d at 1460-61. Thus, where Congress has found that a procedure explicitly required by the statute is a useless exercise, it has not hesitated to avoid that procedure. The Secretary should not be allowed to mandate a similarly useless exercise where it is *not* required by the statute.

Given the mechanical audit function of the intermediary in reviewing the accuracy of the amount, classification and apportionment of costs entered in the cost report, the intermediary's role is not in any way diminished by giving the PRRB jurisdiction to review provider claims with respect to costs that have been self-disallowed in accordance with the Medicare statute, regulations and manual instructions. Indeed, when the provider follows such instructions in completing the cost report, the intermediary's role is facilitated, since the intermediary would otherwise have to recalculate the entire cost report after reapportioning malpractice costs to conform them to the methodology of the regulation.

Since in this case no useful purpose is served by requiring that claims be submitted to an entity that cannot grant relief, there are no policy considerations to support the agency's restrictive interpretation of the statute. Thus the self-disallowance rule cannot be viewed as a valid exercise of exhaustion of remedies, but should be treated as what it really is: an agency rule which precludes judicial review.

(2) *Deprivation of Intermediary Analysis.* Contrary to the concern expressed by the *Athens* court, the PRRB is not deprived of the intermediary's analysis and conclusions when it takes jurisdiction over self-disallowed costs. First, the intermediary's determination with regard to self-

disallowed costs would be nothing more than what has already been done by the provider itself, i.e., to apportion costs in accordance with the regulation. The only difference between a self-disallowance and the intermediary audit adjustment is that the intermediary includes a reference to the regulation or instruction on which the adjustment is based in the audit adjustment report. Secondly, because the intermediary cannot review the validity of the regulation, it has no analysis to offer. *Adams House,* 817 F.2d at 592; *Baptist Hospital East,* 802 F.2d at 865.

And third, to the extent that the self-disallowance involves a challenge to a manual provision which the PRRB can decide (as opposed to a regulation by which the Board is bound), the intermediary is a party to the PRRB proceedings. 42 C.F.R. § 405.1843 (1986). At the hearing in such a case, the intermediary can offer a full analysis and its conclusions with regard to the correctness of a manual instruction.

Accordingly, the loss of the intermediary's analysis that concerned the *Athens* court is hardly a basis for denying a provider the right to be heard in a challenge to a regulation or manual instruction that the provider followed in completing its cost report.

(3) *PRRB as original tribunal.* The *Athens I* panel's concern that the PRRB would become a "tribunal of original jurisdiction" arises from the court's erroneous characterization of the filing of a cost report as a "proceeding". This concern is groundless because, in fact, Congress fully intended the PRRB to be, at least in part, a tribunal of original jurisdiction.

The intermediary's primary function is to audit the costs of services provided and to administer payments, not to resolve policy disputes. S.Rep. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1992-95. *See also Heckler v. Community Health Services of Crawford County,* 467 U.S. 51, 64 (1984). There is no

evidence that Congress intended that the intermediary be the initial reviewer of a provider's challenges to the Secretary's policies.

The Secretary's position that a provider must first somehow raise a dispute with the intermediary over the Secretary's regulations has the effect of comparing the filing and auditing of a cost report with the activity of a "trial" court prior to appeal to an appellate court. The activities are not comparable. The cost report is simply an accounting document which presents the provider's costs for that year in an accounting manner dictated by the Secretary and the Medicare statute. The intermediary's job is to audit that document in an accounting sense, not to act as a tribunal. Since the intermediary does not sit as a tribunal when it receives the cost report and there is no adversary process triggered by submission of the cost report, this concern provides no basis for denying a right to be heard.

The First and Ninth Circuits correctly recognized that the Board has a hybrid function. While it does "review" certain intermediary actions, Congress also gave the PRRB the role of an initial factfinder, with the power to hear witnesses from both sides and take new evidence. *St. Luke's Hospital,* 810 F.2d at 328; *Adams House,* 817 F.2d at 592-93. Thus Congress expressly indicated that the Board was to be the initial tribunal, not merely an appellate body.

b. *There Is No Possibility Of Stale Claims*

In addition to the exhaustion of remedies concerns, both *Athens* decisions raised the concern that allowing *de novo* claims to supplement the claims already before the PRRB, as the *Athens* providers were attempting to do, would render meaningless the time limits for filing cost reports and generate baseless appeals to protect against forgotten costs. *Athens I,* 686 F.2d at 997; *Athens II,* 743 F.2d at 7. This may be true with regard to claims for costs

that have not in any way been included in the cost report or otherwise presented to the intermediary. This concern, however, obviously does not apply with regard to self-disallowed costs for which the provider has appealed to the PRRB (whether included in the original request for hearing or later added to the hearing request pursuant to 42 C.F.R. § 405.1841(a) (1986)),[13] because those costs are already in the cost report. *Adams House*, 817 F.2d at 593.

It should be noted that in *Athens I*, the court took care to distinguish self-disallowed costs on the basis that, through the process of self-disallowing cost in accordance with the regulations or instructions, the provider had given the intermediary notice of the costs and the opportunity to determine whether reimbursement was proper. On rehearing, apparently prompted in part by the suggestion that at least one of the costs at issue would be deemed to be a self-disallowed cost, the court in *Athens II* retreated from its exception for self-disallowed costs, holding:

> At best, [the hospital's] claim with respect to the income tax costs can be characterized as a "self-disallowance." Its claim with respect to stock option cost is clearly not even that, for [the hospital] contends only that it was "directly related" to a category of cost in issue. Petition for Rehearing at 57. As such, the PRRB was correct in holding that it did not have jurisdiction to consider these costs because the intermediary was never given the opportunity to make a final determination about them.

743 F.2d at 10.

As part of that holding, *Athens II* distinguished between "listing a cost on the cost report and claiming reimbursement for a particular cost because the cost report lists both non-reimbursable and reimbursable costs." *Id.* at 3, n.2.

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[13] 42 C.F.R. § 405.1841(a) (1986) provides, in relevant part:

> . . . Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

Then, the court stated: "The essence of our holding today is that unless the provider includes a *category* of costs in its request for reimbursement, the intermediary is not obligated to determine whether reimbursement may be had for the cost items that make up that category." *Id.* (Emphasis in original.) If that was indeed the essence of the holding, then the self-disallowed costs at issue here *should* have been heard by the Board, since they *are* a part of a *category* of costs included in the cost report. *See* Worksheet D-8, Jt. App. 58a-61a.

c. *There Is No Possibility Of Frivolous Costs*

The *Athens II* court suggested that the interpretation urged by the Hospitals would have another set of significant adverse practical consequences. Those consequences were that a provider could "list every conceivable cost on its cost report, without claiming reimbursement, and hope that the intermediary will reimburse it for the reported but unclaimed costs, secure that it nevertheless will have until 180 days following the NPR to concoct some reasons to urge the PRRB for reimbursement of the unclaimed costs." 743 F.2d at 6. What the court apparently failed to recognize is that the provider already is required to list every conceivable cost in the cost report, and then to classify and categorize those costs as reimbursable or non-reimbursable in acccordance with the regulations and manual instructions. Since the intermediary has no option but to disallow costs claimed in contravention of manual instructions and regulations, it simply does not matter whether those costs were aggressively entered contrary to regulation, or whether the instructions or regulations were followed in completing the cost report. In addition, as the Ninth Circuit noted in response to *Athens*, any "frivolous padding" of cost reports is protected against by the anti-fraud provisions of 42 U.S.C. § 1395nn (1982).[14] *Adams House*, 817 F.2d at 592.

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[14] Pursuant to Pub. L. No. 100-93, § 4, 101 Stat. 680 (1987), this section will be moved but has not yet been assigned a new United States Code section number.

The *Athens II* court then expressed the concern that the provider would be able to claim reimbursement from the intermediary for costs on one basis and then recharacterize its costs and seek reimbursement on a totally different basis before the PRRB. 743 F.2d at 6. Unless the court's concern was that the provider would list malpractice premium cost as nursing costs or some other category of cost, and then seek a hearing on the basis that the nursing costs should have been paid as malpractice costs, this concern is without merit. Other than placing a number in the cost reporting form across from the various descriptions of the kinds of cost being listed, the provider does not "characterize" its cost for the intermediary.

d. *There Is No Conflict With The Reopening Regulations*

The *Athens II* court also was concerned that the interpretation that the PRRB has jurisdiction to hear issues not disputed with the intermediary would be "inconsistent with the reopening regulations provided by regulation . . . . [in that] if specific claims were not required, an intermediary's denial of a reopening request often could not be final, contrary to 42 C.F.R. § 405.1885(c) (1986)."[15] *Id.* at 7. This argument has meaning only in an *Athens*-type case, where a provider has appealed to the Board, then attempts to have the cost report reopened to include omitted costs. Even then, as the Ninth Circuit recognized, an "[a]ppeal to the Board does not force an intermediary to reopen its deliberation against its will. There is finality at the intermediary level." *Adams House*, 817 F.2d at 593.

The idea that this potential lack of finality should prevent Board jurisdiction stems from the incorrect notion that the Board exercises purely a power of review with no element of initial jurisdiction. *Id.*; *see also* pages 32-33, above. Moreover, the *Athens* court's concern as to the

[15] 42 C.F.R. § 405.1885(c) (1983) provides:

> Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

conflict with the reopening regulations is irrelevent to the issue of a right to be heard on self-disallowed costs which were on the original cost report and for which a provider has not requested reopening of its cost reports.

In summary, none of the alleged adverse consequences raised by the *Athens* court justify precluding the Board from taking jurisdiction over appeals of providers that self-disallow by following regulations or manual instructions. No reasonable purpose is served by disputing a regulation with an intermediary that is bound by the very regulation. The costs are timely listed on the cost report and are not stale. And finally, there is no conflict with the Secretary's reopening regulations. Without such practical underpinnings, and in light of the most natural and easy reading of the language of the statute, the Secretary's interpretation cannot be considered to be reasonable.

2. *The Secretary's Interpretation Is Only An Informal Policy, Was Not Developed Contemporaneously With The Statute, Has Not Been Consistently Applied, And Reflects The Agency's Hostility To Administrative And Judicial Review.*

The Secretary's interpretation that the PRRB has no jurisdiction to hear appeals of self-disallowed costs is contained nowhere in the Medicare regulations. To the extent the policy is arguably articulated anywhere in the Medicare Provider Reimbursement Manual, it appears only in sections dealing with fraud and abuse warnings.[16]

It is recognized that informal agency policies or guidelines may be accorded significantly less deference than administrative regulations, established pursuant to notice and comment provisions, which may have the force of law. *General Electric Co. v. Gilbert*, 429 U.S. 125, 143 (1976), *reh'g denied*, 429 U.S. 1079 (1977). The time-worn test to determine to what degree, if any, such informal policies are entitled to deference was set forth in *Skidmore v. Swift & Co.*: "The weight of [an agency's] judgment in a

[16] See discussion in Section IV, below.

particular case will depend on the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). *Accord, Morton v. Ruiz*, 415 U.S. 199, 237 (1974). Under this test, the Secretary's interpretation is not entitled to deference.

First, the Secretary's policy was not developed contemporaneously with the enactment of section. The Board did not begin to articulate the self-disallowance policy until the early 1980s, some eight years after the promulgation of the statute. To the extent they may be relevant at all, the manual provisions concerning the claiming of non-allowable costs in the context of prosecution for fraud were not issued until December 1978.

In an analogous situation, this Court has indicated its willingness to limit judicial deference of an administrative interpretation of a statute. In *General Electric Co. v. Gilbert*, the Court cited the test from *Skidmore v. Swift*, and concluded that the guideline at issue "did not fare well under these standards [as] it [was] not a contemporaneous interpretation of [the statute]. . . ." 429 U.S. at 142.

Moreover, even after the Secretary developed this interpretation, the agency has not consistently applied it, leaving providers in a situation of not knowing what the agency will do. The First Circuit pointed to at least four cases in which the PRRB accepted jurisdiction over self-disallowed cases. *St. Luke's Hospital*, 810 F.2d at 331.

In addition, the Eleventh Circuit has considered the merits of a case in which the PRRB originally exercised jurisdiction over self-disallowed costs. In *Charter Peachford Hospital Inc. v. Bowen*, 803 F.2d 1541 (11th Cir. 1986), the Court of Appeals specifically noted:

> . . . Although Charter Peachford did not originally claim reimbursement for the salaries on its 1980 cost report, it later appealed the intermediary's disallowance of these costs to the Provider Reimbursement Review Board . . . .

Id. at 1543. The PRRB exercised jurisdiction over the appeal of those costs, invoking its authority to hear matters not considered by the intermediary as contained in section 1395oo(d) and 42 C.F.R. § 405.1869 (1986).[17] This is evident from the excerpts of the transcript of the proceedings brought by Charter Peachford Hospital before the PRRB. *See* Jt. App. 64a-67a. Upon appeal to the courts, the Secretary did not challenge PRRB jurisdiction.

A final factor demonstrates that the Secretary cannot be expected to render a reasonable interpretation of statutory language relating to a provider's right to judicial review. Since the inception of the Medicare program, the Secretary has endeavored to deny providers both administrative and judicial process with regard to their claims that they have been short-changed for services provided to Medicare beneficiaries. All gains by the providers for any kind of fair process concerning disputed claims have been obtained only over obdurate resistance by the Secretary.

From the beginning of the Medicare program in 1966 through 1972, the Secretary offered *no* dispute resolution process for providers aggrieved by the level of Medicare reimbursement. Rather, the Secretary relegated provider complaints to informal discussions or review by representatives of the intermediary. During this period, the Secretary successfully fought and resisted provider access to the courts on such claims. *See, e.g., Schroeder Nursing Care, Inc. v. Mutual of Omaha*, 311 F. Supp. 405 (E.D.

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[17] 42 C.F.R. § 405.1869 (1986) provides:

> The Board shall have the power to affirm, modify, or reverse a determination of an intermediary with respect to a cost report and to make any other modifications on matters covered by such cost report (including modifications adverse to the provider or other parties) even though such matters were not considered in the intermediary's determination. The opinion of the majority of those Board members deciding the case will constitute the Board's decision.

Wisc. 1970); *Wilson Clinic & Hospital, Inc. v. Blue Cross of South Carolina,* 494 F.2d 50 (4th Cir. 1974).

The Courts, however, soon began to question the Secretary's failure to provide a fair process for dispute resolution and the Secretary's fight against judicial review. *See, e.g., Coral Gables Convalescent Home v. Richardson,* 340 F. Supp. 646 (S.D. Fla. 1972) ("This Court, like the Second Circuit in *Acquavella* . . . is disconcerted by defendants' contention that plaintiff is entitled to neither administrative nor judicial review . . ."); *Whitecliff, Inc. v. United States,* 536 F.2d 347, 349-51 (Ct. Cl. 1976), *cert. denied,* 430 U.S. 969 (1977).

For cost reporting periods ending on or after December 31, 1971 through June 30, 1973, the Secretary fashioned a more formalized dispute resolution process consisting of a "hearing" before a panel established by the provider's intermediary. 42 C.F.R. § 405.490 (1974). This process was found defective and an injunction issued in *St. Jude Manor Nursing Home, Inc. v. Richardson,* No. 72-681-Civ-J-S (M.D. Fla. Oct. 3, 1972), *reprinted in* Medicare and Medicaid Guide (CCH) ¶ 27,226). The Secretary strenuously resisted provider access to the federal courts following this hearing process. *See, e.g., Temple University v. Associated Hospital Service of Philadelphia,* 361 F. Supp. 263 (E.D. Pa. 1973); *Sacred Heart Hospital v. United States,* 616 F.2d 477, 482 (Ct. Cl. 1980) ("Defendant once again challenges this court's jurisdiction over a portion of this Medicare case. As to the years 1967 through fiscal year 1972, defendant apparently finally accepts this court's jurisdiction. . .").[18]

[18] The Secretary again tried to prevent providers from having any access to judicial review with respect to the implementation of PPS. In his Report to Congress on Hospital Prospective Payment For Medicare, the Secretary stated:

> Payment amounts, exceptions, adjustments, and rules to implement the prospective payment system would not be subject to any form of judicial review . . . The omission of judicial review follows the current statutory provisions related to determinations under Medicare Part B where judicial review is also prohibited. As with any service sold to the Government, the remedy for providers dissatisfied with the rate offered is to convince the purchasing agency that a higher rate is appropriate or, failing that, to refrain from offering services to the Government.

Report sent to House Committee on Energy and Commerce, 136 Cong. Rec. H 8573 (1982). Congress rejected this blatant attempt to foreclose all access to judicial review by amending section 1395oo(a) to specifically give hospitals a right to appeal their PPS payments. Pub. L. No. 98-21, § 602(h)(1), 97 Stat. 65 (1983). And in *Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667 (1986), this Court rejected the notion that all judicial review was prohibited under Part B, finding that the legality of a regulation setting forth the methodology used by the Secretary to compute Part B payments was subject to review.

Given the Secretary's history of resistance to judicial review and the courts' rejection of those attempts, the Secretary's present hard-line position should not be accorded the status of a reasonable interpretation or be made the basis for the denial of the providers' right to be heard.

III. SECTION 1395oo SHOULD NOT BE INTERPRETED TO CONTAIN AN IMPLIED DELEGATION OF DISCRETIONARY POWER TO THE SECRETARY OR THE PRRB TO LIMIT OR FORECLOSE ADMINISTRATIVE AND JUDICIAL REVIEW.

In *St. Luke's,* the First Circuit found that the PRRB's authority to revise aspects of the cost report that had not been considered by the intermediary constituted a discretionary power to assume or decline jurisdiction over claims for self-disallowed costs. That conclusion was not based upon any express delegation of power in subsections (a) or (d), but rather was a matter of interpretation. As discussed above at page 21, the *St. Luke's* interpretation was based upon a misreading of the statutory language. However, assuming *arguendo,* that such a reading could be supported, then the question must be asked whether the language of subsections (a) or (d) *should* be interpreted to include such a delegation of power to the agency. For the following reasons, the Hospitals suggest it should not.

First, it should be noted that the only express delegation in either subsection 1395oo(a) or (d) that gives the Secretary any power to limit the provider's access to administrative and judicial review is with respect to specifying the time within which the cost report must be filed with the intermediary. That does not constitute a delegation of power to interpret those subsections in a manner that forecloses review for self-disallowed costs. Such express power being lacking, it should not be implied.

In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this Court relied upon the presumption of reviewability to find a right to judicial review with respect to the method of determining reimbursement for physician services under Part B of the Medicare program. If the presumption of reviewability was sufficient to overcome the limitations of 42 U.S.C. § 405(h) (1982) within the context of *Michigan Academy*, it should militate against an interpretation of subsections (a) or (d) that would imply a discretionary power in the agency to foreclose administrative and judicial review by imposing threshold procedural requirements beyond those required by the statute. This is particularly the case where the statutory provisions to be interpreted constitute a broad congressional grant of administrative and judicial remedies for providers dissatisfied with the amount of reimbursement received for their services.[19]

In addition to the presumption of reviewability, there is another policy observed by this Court that operates

[19] Interpreting section 1395oo(g) (1982), the Eleventh Circuit in Memorial Hospital v. Heckler, 706 F.2d 1130 (11th Cir. 1983), *cert. denied*, 465 U.S. 1023 (1984) found that subsection (g) should not be read to preclude judicial review of a challenge to the Secretary's regulation listing patient telephone costs as an example of noncovered personal comfort items under section 1395y(a) (1982). The court stated:

> "To expand the non-reviewability of intermediary decisions to include policy decisions of the Secretary would not merely insulate from judicial scrutiny the finding of an intermediary. It would give the Secretary virtually unbridled discretion to prevent reimbursement through regulations. Such a result would run contrary to the presumption favoring judicial review.

Id. at 1133.

Giving the agency the discretionary power to foreclose review through agency interpretation of the threshold requirements for review operates to create a similar mischief. In this instance the Secretary can avoid being required to pay for services rendered by some providers while being made to pay others simply by imposing threshold jurisdictional requirements beyond those required in the statute which may not be met by some providers. In a second case involving the Secretary's attempt to restrict administrative and judicial review under section 1395oo(a) for claim under PPS, the D.C. Circuit found that "congressional intent is clear and there is no implicit delegation of authority to the Secretary to interpret the review provision." Washington Hospital Center v. Bowen, 795 F.2d 139, 147 n. 10 (D.C. Cir. 1986).

against an interpretation of section 1395oo that finds such an implied delegation to the agency. That policy arises from the fact that section 1395oo, granting administrative and judicial review against the Secretary, constitutes a waiver of sovereign immunity. In *Bowen v. City of New York*, __ U.S. __, 106 S.Ct. 2022 (1986), as part of the analysis of whether the Secretary's secret policies should toll the statute of limitations in 42 U.S.C. § 405(g) (1982), this Court stated:

> In construction of the statute [waiving sovereign immunity], we must be careful not to "assume the authority to narrow the waiver that Congress intended,". . . or construe the waiver "unduly restrictively".

Id. at 2029 (citations omitted). If this Court imposes such a standard itself, it hardly seems consistent to imply an interpretative power in the Secretary to impose threshold impediments not clearly required by statute. This particularly is the case where, as here, the entire thrust of the Secretary's conduct has been to seek to narrow or limit access to the congressionally granted waiver of sovereign immunity.

To the extent the *St. Luke's* court would read section 1395oo to delegate to the Secretary or the PRRB an im-

plied discretionary power to limit or restrict the waiver of sovereign immunity, it is incorrect. It also runs counter to the presumption of reviewability. In short, as discussed above, there are ways to read section 1395oo which provide the desired administrative and judicial remedies for providers wishing to claim reimbursement for self-disallowed costs without vesting discretionary jurisdiction in the Secretary or the PRRB. Those readings should be preferred over the *St. Luke's* reading.

IV. THE SECRETARY CANNOT PRECLUDE JUDICIAL REVIEW WITHOUT NOTICE

Assuming *arguendo* that the Secretary's policy concerning self-disallowed costs is consistent with the statute and is therefore permissible, that policy appears nowhere in Medicare regulations. Providers are told to fill out cost reports in a manner consistent with applicable law, regulations and policy manuals. They are also admonished not to commit fraud and abuse, which includes making claims for payments not allowable under the regulations and manual. Providers are not told that the only way they can preserve their appeal rights is to violate both of these requirements.

To require the preservation of claims according to procedures announced *post hoc* would, at best, require a provider to read the agency's mind. The fact is that the Hospitals were not given notice by the agency or the intermediary that, when they complied with the Secretary's regulations in completing their cost reports, they were forfeiting their appeal rights. Under these circumstances, the Secretary cannot preclude judicial review, for to penalize a person for failing to follow an unpublished or, indeed, a non-existent rule raises serious due process issues. *See, e.g., Brinkerhoff-Faris Trust & Savings Co. v. Hill,* 281 U.S. 673, 678-79, 681-82 (1930).

The *Athens II* court referred to section 2425.1 of the Provider Reimbursement Manual (HIM-15) as establishing a "formal procedure by which providers could . . . preserve appeal rights by including the disputed costs in

their allowable costs and disclosing the existence of such costs to the Medicare intermediary." 743 F.2d at 10. *See also St. Luke's Hospital,* 810 F.2d at 332. Although this provision existed since 1979, *id.,* by its own terms it does not apply to the factual scenario faced by these Hospitals.

Section 2425.1 deals with possible referrals to the United States Attorney for consideration of criminal and/or civil prosecution for fraud where a provider claims reimbursement for costs not allowed under the regulations. It provides as follows:

> There will be no referral to the U.S. Attorney if the allowability of a cost report item or items have been or are being disputed, and the provider clearly indicates on the *subsequent* cost report that the items are included, and the reason for inclusion (i.e., such as to preserve the provider's right to appeal, or other legal rights.) (Emphasis added.)

As evidenced by the underscored language, this provision applies only to a situation in which a provider seeks reimbursement of a cost that was disallowed on a previous cost report and the previous disallowance is still under appeal.

This is confirmed by HCFA Transmittal No. 213, December 1978, which accompanied the issuance of section 2425.1:

> *2425.1, Nonallowable Cost Report Entries,* is a new section which manualizes current procedures dealing with the problem of repeated (year after year) entries of nonallowable items on Medicare cost reports. Where a provider knowingly includes *previously disallowed costs,* which are not being appealed, on a subsequent cost report, the provider will be notified of possible referral to the U.S. Attorney for consideration of criminal and/or civil prosecution if the disallowed costs are included in a future cost report. (Emphasis added.)

Thus, where costs are disallowed in one year and the provider either does not appeal or loses an appeal, if the pro-

vider attempts to claim the same costs in the next year, the intermediary may refer the case for prosecution. If, on the other hand, the provider appeals the disallowance in the first year and wishes to continue to appeal in subsequent years, no referral will be made if the provider discloses this intent on the cost report. However, this section provides no instructions on how a provider is to preserve its appeal in the first year. Nor can it reasonably be construed to provide notice that if a provider completes its cost report by following the regulations, it has waived any right to challenge that regulation in the PRRB and the courts.[20]

[20] The *St. Luke's Hospital* decision states that the accompanying memorandum indicates section 2425.1 was issued "so that providers will not be discouraged from exercising their statutory rights of appeal." 810 F.2d at 332. This refers to Transmittal No. 225, August 1979, which states in full:

> *Section 2425.1, Nonallowable Cost Reports Entries,* is revised so that providers will not be discouraged from exercising their statutory right to appeal. There is new language to show that repeated inclusion of nonallowable entries in cost reports could result in provider termination from the program.

This language again indicates that section 2425.1 is directed at *repeated* claims for nonallowable costs, and does not apply in this situation.

CONCLUSION

For the foregoing reasons, the decision of the court of appeals should be reversed, and the case should be remanded with instructions to pay the Hospitals in the same manner as the other providers in the case below.

Respectfully submitted,

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NOVEMBER 1987

APPENDIX

STATUTE INVOLVED

42 U.S.C. § 1395oo. Provider Reimbursement Review Board.

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –

(1) such provider –

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied

with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragragh (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

* * *

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

* * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and

has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly be several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

* * *